STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		4/19/17

An unannounced annual survey was conducted at this facility from February 8, 2016 through February 16, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records, other facility documentation and State Survey Agency Intake records as indicated. The facility census the first day of the survey was 95. The Stage 2 survey sample size was 26.

Abbreviations / definitions used in this report are as follows:
ADL / Activities of Daily Living - tasks needed for daily living, for example, dressing, hygiene, eating, toileting, bathing;
ADON - Assistant Director of Nursing;
Adverse consequence - an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status; it may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended;
Antipsychotic- medication used to treat psychotic disorders:
B&B - Bowel and Bladder;
CAAs / Care Area Assessment(s) - Summary that identifies potential problem care areas;
Cardiology - branch of medicine that deals with diseases and abnormalities of the heart;
C-Diff / Clostridium Difficile Colitis - bacteria that can cause swelling and irritation in the bowel, may cause diarrhea;
CNA(s) - Certified Nurse's Aide;
Cognition-process of knowing perception;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard Powell	NHA	3/14/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Continent - control of bladder; Dementia-mental disorder that impairs reasoning and memory; DON - Director of Nursing; EKG - electrocardiogram (EKG or ECG) is a test that checks for problems with the electrical activity of your heart; an EKG shows the heart's electrical activity as line tracings on paper; eMARs - electronic medication administration records; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Incontinent - loss of control of bladder; MDS / Minimum Data Set - standardized assessment forms used in nursing homes; Mobilex - outside provider of various diagnostic tests that comes into the facility; N/A - Not applicable; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Occasionally Incontinent - less than 7 episodes of incontinence during a 7 day look back period; POA / power of attorney - someone appointed to make decisions on your behalf; PRN - as needed; psychotic-insane, mad; QT interval - the measure of time of activity of the lower chambers of the heart reflected on an EKG reading; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SS - Social Services; SW - Social Worker; Tramadol-medication used to treat severe pain; UM - Unit Manager; Vicodin- pain reliever; Voiding diary-a record of urinating for 72 hours or	F 000		4/19/17

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F 000	Continued From page 2	F 000		4/19/17

three days.

F 225 SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225

(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours

Richard Powell NHA 3/14/17

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F 225	Continued From page 3 after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, review of facility policy, other documentation and review of State Survey Agency Intake records, it was determined that for one (R135) out of 26 Stage 2 sampled residents, the facility failed to immediately report an allegation of abuse to the State Survey Agency in accordance with State law. Findings include: According to Title 16 Health and Safety of the Delaware Administrative Code for Skilled and	F 225	A. 1. R135 allegation of abuse has been reported to the state. B. 2. All residents that recant their statement have the potential to be affected by this practice. C. (1) Abuse training education will now include the need to report allegation to State Survey Agency regardless if the resident recants their statement. (b) The Staff Developer will educate staff on the need to report all abuse and neglect allegations to State Survey Agency regardless if the resident "recant" their statement, D. (1) All allegations of abuse and neglect will be audited by the ED/designee to monitor that alleged allegations of abuse were reported in accordance with state law. (2) Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	4/19/17

Richard Powell RNHA 3/14/17

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F 225	Continued From page 4	F 225		4/19/17

Intermediate Care Nursing Facilities, Section 9.6 stated, "Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection...9.8 Reportable incidents are as follows: 9.8.1 Abuse...9.8.1.1...physical abuse with or without injury if staff to resident...".

The facility's policy entitled, Freedom From Abuse, Neglect, and Exploitation, effective date 12/26/16, stated, "...Identification: ...3. The facility will report the allegation to the State Agency in accordance with state law...".

2/8/17 at 3:48 PM - During a resident interview with a State Surveyor, R135 stated that he observed a physical altercation between a staff person and another resident, R121. When asked if R135 reported it to facility staff, R135 stated no. The State Surveyor informed R135 that she was mandated to immediately report allegations of abuse to the facility management so they could investigate.

2/8/16 at 3:52 PM - The State Surveyor reported the allegation of abuse to E2 (DON).

2/8/17 through 2/15/17 - Review of the State Agency's Intake records revealed that the facility failed to immediately report the allegation of abuse in accordance with State law.

2/10/17 - Review of the facility's Grievance/Concern Form stated that R135 reported an incident to the State Surveyor and the State Surveyor reported the incident to the E2.

2/10/17 - Review of the facility's Verification of

Richard Rendl NHA 3/14/17

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F 225	Continued From page 5 Investigation form stated that the facility was unable to substantiate the allegation of abuse based on their investigation, which included interviews with R135, R121 and staff. 2/16/17 at approximately 11:30 AM - During an interview, E2 stated that the facility did not have to report it to the State Survey Agency when R135 "recanted" the story, which occurred during the interview with E2 and E3 (ADON) on 2/8/17. 2/16/17 at 12:39 PM - Further review of the State Agency's Intake records, the facility reported the allegation of abuse. Findings were reviewed during the exit conference on 2/16/17 at 5:50 PM with E1 (NHA) and E2. The facility failed to immediately report an allegation of abuse to the State Survey Agency.	F 225	4/19/17 F241 A. 1. The facility cannot retrospectively go back to 2/8/17 and have E9 ask permission to enter R25, R34, R76, R94 and R126 rooms. B. All residents have the potential to be affected by this practice. C. (a) The Staff Educator will educate all disciplines on the need to knock and ask permission before entering a resident's room. (b) The need to knock and ask permission before entering a resident's room will be added to New Hire Orientation. D. (1) The DON/designee will conduct weekly audits monitoring that staff is knocking and asking permission before entering a resident's room. (2) Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to promote maintenance or enhancement of quality of life in recognizing 5 (R25, R34, R76, R94 and R126) resident's individuality by respecting their private space. Facility staff knocked on resident doors and entered without asking permission to enter	F 241		

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	085026	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 241	Continued From page 6 while delivering meal trays. Findings include: On 2/8/17 from approximately 11:50 AM to 12:05 PM, E9 (CNA) knocked and entered the resident rooms of R25, R34, R76, R94 and R126 to deliver meal trays without asking for permission to enter. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 2/16/17 at approximately 5:30 PM.	F 241		4/19/17
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 6 rooms (East 100, 103, 115, 124, West 103, 107) out of 30 rooms surveyed. Findings include: The following was observed on 2/13/17 from 2:00 PM to 2:45 PM during the Stage 2 environmental tour: East 100 - The bedroom floor was dirty around the perimeter; - The mattress had a large rip on the right side; - The cords for the bedside light and the bed control were wrapped around the left side bed rail;	F 253	F253 A. 1. In room 100 the bedroom floor was cleaned around the perimeter, the mattress has been replaced, and the cords have been removed from the bedside rail. 2. In room 103 the bedroom and the bathroom was cleaned around the perimeter. the loose door handle and the left side bed rail was tightened. 3. In room 115 emergency power outlet was fixed. 4. In room 124 the overhead light pull cord was replaced with a longer cord. 4. In room 103 the wall between the sink and bathroom door was clean, the bedroom and the bathroom floors were cleaned, the air conditioning unit was cleaned. 5. In room 107 the left side rail was fixed, and the floor were clean.	

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	065025	A. BUILDING _____ B. WING _____	02/16/2017

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F 253	Continued From page 7 East Room 103 - The floors in the bedroom and the bathroom were dirty around the perimeter; - The door handle on the front of the bedroom door was loose; - The left side bed rail was loose; East Room 118 - The A bed emergency power outlet was cracked; East 124 - The over head light pull cord was too short; West 103 - The wall between the sink and the bathroom door had dried spill stains; - The bedroom and the bathroom floors were dirty; - The air conditioning unit had debris in the vent; West 107 - The left side bed rail was unable to be pulled up all the way; - The floors were dirty. Findings were reviewed and confirmed with E10 (Director of Housekeeping), E11 (Director of Maintenance) on 2/13/17 at approximately 2:45 PM. Findings were reviewed with E1 (NHA) and E2 (DON) on 2/16/17 at approximately 5:50 PM.	F 253	F253 B. 1. All residents have the potential to be affected by this practice. 2. The ED, Director of Housekeeping and the Maintenance Director will round all resident's rooms to monitor general condition of rooms and cleanliness. Repairs will be made accordingly. C. 1. Weekly rounds with ED, Director of Housekeeping and Director of maintenance will be initiated to monitor general condition and cleanliness of the resident rooms. D. 1. The ED/designee will audit 25% of resident's room weekly for general repair and cleanliness.. 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	4/19/17
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		

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	085026	A. BUILDING _____ B. WING _____	02/16/2017

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F 278	Continued From page 8 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R85) out of 26 Stage 2 sampled residents, the facility failed to accurately reflect his urinary status on the 1/19/17 quarterly MDS assessement. Findings include:	F 278	F278 A. R85 no longer resides in the facility. B. 1. All residents have the potential be affected. 2, The MDS/Coordinator will audit all residents that had a MDS submitted in the past 30 days to determine if urinary status has been accurately coded on their MDS. Corrections will be made accordingly, C. 1. The MDS Coordinator/designee will now run an Data Integrity Audit report (DIA) from the Point Right software. The DIA report and the MDS will be reviewed and compared to determine if the resident's urinary status has been accurately coded. Correction will be made accordingly. 2. The MDS Coordinator/designee will audit 100% of MDS's submitted for accuracy. D. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	4/19/17

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F 278	Continued From page 9 Review of R85's clinical record revealed: Review of R85's ADL Record from 1/13/17 through 1/19/17 revealed that he was both continent and incontinent of urine. The 1/19/17 quarterly MDS assessment stated that R85 was always incontinent of urine. E4 (RNAC) was interviewed on 2/16/17 at 10:43 AM and confirmed that the coding of R85's urinary status as always incontinent of urine was incorrect. E4 stated that the assessment should have been coded as frequently incontinent of urine. Findings were reviewed with E2 (DON) and E6 (UM, RN) on 2/16/17 at 11:52 AM. The facility failed to accurately reflect R85's urinary status on the 1/19/17 quarterly MDS assessment.	F 278		4/19/17
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279	F279 A. R85's no longer resides in the facility, B. 1. All residents that have urinary incontinence have the potential to be affected. 2. The MDS Coordinator/designee will do an all house audit of residents that are incontinent to monitor that they have individualized incontinence care plans. Individualized incontinence care plans will be initiated accordingly. c. 1. The MDS Coordinator/designee will now run an Data Integrity Audit report (DIA) from the Point Right software. The DIA report and the MDS will be reviewed by the Interdisciplinary team for accurate coding of the resident's urinary status. If a resident is determined to be incontinent an individualized incontinence care plan will be initiated for the resident. d. 1. The MDS Coordinator/designee will audit 100% of MDS's submitted to monitor that residents who are coded as incontinent that they have an individualized incontinent care plan. 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	

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F 279	Continued From page 10 set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279		4/19/17

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F 279	Continued From page 11 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R85) out of 26 Stage 2 sampled residents, the facility failed to develop an individualized urinary incontinence care plan with measurable goals and interventions to address the care and treatment related to services to restore as much bladder function as possible for R85. Findings include: Review of R85's clinical record revealed: R85 was readmitted to the facility on 11/7/16. The 5-day MDS assessment, dated 11/14/16, stated that R85 was frequently incontinent of urine. Review of R85's ADL Records from 11/7/16 through 2/8/17 revealed that he had urinary incontinence. Review of R85's clinical record from 11/7/16 through 2/8/17 revealed the absence of an individualized urinary incontinence care plan. During an interview on 2/16/17 at 11:52 AM, findings were reviewed and confirmed with E2 (DON) and E6 (UM/RN). The facility failed to develop an individualized urinary incontinence care plan for R85.	F 279		4/19/17
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 12 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 (R6) out of 26 Stage 2 sampled residents. The facility failed to consistently assess the numeric pain scale before and after (pre and post) prn pain medication. Findings include: Review of R6's clinical record revealed:	F 309	F309 A. The facility cannot retrospectively go back and add post numeric pain score for R6. B. 1. All residents that received pain medication have the potential to be affected by this practice. 2. The DON/designee will do an house orders on current residents pain medication to monitor that the nurse selected the "task" in the electronic medication record that prompts the software to ask for both a pre and post numeric score. C. 1. The staff developer will re-educate licensed nursing staff on the need to document both pre and post numeric pain scores after administration of pain medication. 2. The Staff Developer will re-educate licensed staff to select the "task" in the electronic medication record that prompts the software to ask for both pre and post pain scores. 3. All new admissions will be reviewed the Unit Manager(s) to audit that the correct "task "was selected. D. 1. Weekly DON/designee will audit 25% of the resident population to monitor that a numeric post score was documented. 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	4/19/17 4/19/17

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F 309	Continued From page 13 10/28/16 (revised 2/7/17) - care plan for exhibits or is at risk for alterations in comfort related to chronic pain listed interventions including medicate as ordered for pain and monitor effectiveness. January and February 2017 - eMARs indicated that numeric pain scale was being used for R6 with acceptable level of pain 3. 1/15/17 - 2/15/17- eMARs included Tylenol [pain medication] to be given every 6 hours prn breakthrough pain 1-5 on numeric pain scale, Tramadol every 6 hours prn chronic pain syndrome and Vicodin every 6 hours prn chronic pain syndrome. 1/15/17 - 2/15/17 - prn eMARs - A. R6 received prn Tylenol 6 times. 5 times (83.3%) lacked a pre pain numeric scale and 6 times (100%) lacked a post pain numeric scale. B. R6 received prn Tramadol 3 times. 2 times (66.6%) lacked a pre pain numeric scale and 3 (100%) times lacked a post pain numeric scale. C. R6 received prn Vicodin 24 times. 12 times (50%) lacked a pre pain numeric scale and 20 (84%) times lacked a post pain numeric scale. The facility recorded prn doses of pain medications as effective or partially effective, although it was determined that a numeric pain scale was to be used. 1/15/17 - 2/15/17- progress notes lacked any of the above missing pre and post pain scales for pain medications.	F 309		4/19/17

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F 309	Continued From page 14 E2 (DON) was interviewed on 2/16/17 at 11:30 AM and findings were reviewed and confirmed.	F 309		4/19/17
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is	F 315	F315 A. 1. R75 and R85 no longer resides in the facility, B. 1. All residents have the potential to be affected. 2. All residents that has had a Bowel and Bladder evaluation conducted in the past 90days will be reviewed by the ADON/designee to monitor for thoroughness; completion and an analysis of the resident's 3 day voiding, personalization of urinary care plans and the effectiveness of the resident's toileting plan. In addition the accuracy of the MDS coding will be reviewed. All corrections will be made accordingly.	

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incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews and interviews, it was determined that for two (R74 and R85) out of 26 Stage 2 sampled residents, the facility failed to ensure that residents who are incontinent of bladder received appropriate treatment and services to restore continence to the extent possible. For R74, the facility failed to ensure an accurate and complete comprehensive assessment and they failed to develop an individualized toileting plan. For R85, the facility failed to comprehensively assess his urinary incontinence after multiple readmissions to the facility on 11/7/16, 11/29/16, 12/2/16, 12/27/16 and 1/26/17; failed to develop an individualized urinary incontinence care plan; failed to address his "ineffective" (as per CNA monitoring) toileting program; and failed to accurately reflect R85's urinary status on the 1/19/17 quarterly MDS assessment. Findings include:

The facility's policy titled "Bowel and Bladder Management," effective date 3/26/13, stated, "...Procedure: 1. Each resident will be assessed for bowel and bladder functioning on admission, quarterly and any change in condition. 2. A bowel and bladder evaluation will be completed as indicated. If a resident is continent, a bowel and bladder evaluation does not need to be completed. 3. Upon completion of the bowel and bladder evaluation, a plan of care will be developed. 4. This plan of care may include a bladder retraining program, prompted voiding, scheduled voiding or check and change program...".

c. 1. The MDS Coordinator/designee will now run an Data Integrity Audit report (DIA) from the Point Right software. The DIA report and the MDS will be reviewed by the interdisciplinary team for accurate coding of the resident's urinary status. If a resident is determined to be incontinent an individualized incontinence care plan will be initiated for the resident. 2. The DIA report and the MDS will be reviewed and compared between reports to determine if the resident's urinary status has been accurately coded. 3. Now Unit Managers will bring all voiding diaries to the morning meeting so they can tracked on the center's white board. The ADON /designee will analyze resident's voiding dairies, develop toileting plans that review effectiveness as needed,

D. 1. The MDS Coordinator/designee will audit 100% for the accuracy of residents' urinary status, coding accuracy and the completeness of the Bowel and Bladder evaluation that includes determining effectiveness of the toileting plan. . 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.

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1. Review of R74's clinical record revealed the following:

8/23/16 - R74 was admitted to the facility with diagnoses that included a broken right thigh bone and heart disease.

8/23/16 9:45 PM - The Clinical Admission Documentation report checked off that R74 had "no obvious problem" with urinary function. The document did not identify urinary incontinence.

8/24/16 3:30 PM - A Practitioner Progress Note, completed by an NP, stated that R74 denied any bladder problems.

Review of the ADL Record, completed by CNAs, revealed the following:
- 8/23/16 - on the 7 AM to 3 PM and 3 PM to 11 PM shifts, it was documented R74 was continent of bladder;
- 8/24/16 through 8/31/16 - on both the 7 AM to 3 PM and 3 PM to 11 PM shifts, it was documented R74 was totally incontinent of bladder;
- 8/24/16 through 8/31/16 - on the 11 PM to 7 AM shift, it was documented R74 was totally continent of bladder.

8/24/16 5:06 AM - A nurse's progress note stated, "...remained continent of B&B, able to use the bed pan with assistance...".

8/24/16 through 8/25/16 and 8/27/16 - A Bowel and Bladder Evaluation which included a 72 hour voiding diary (3 day voiding diary) was completed. Review of the evaluation revealed that the 3 day voiding diary had no data entered from 11 PM through 6 AM on 8/24/16. Additionally, the facility

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failed to identify the type of incontinence R74 had, they failed to identify the type of toileting program and the reason for it, and the evaluation was not signed by a nurse, nor was it dated. The facility failed to ensure that a comprehensive 3 day voiding diary was completed for R74, and to complete the Bowel and Bladder Evaluation, including an individualized toileting plan.

8/30/16 - An admission MDS assessment stated that R74's daily decision making skills were independent, that R74 required extensive assist of two (2) staff for bed mobility, and was totally dependent on one (1) staff for toilet use. The MDS also stated R74 was frequently incontinent of bladder, a trial of a toileting program had been attempted but the response was unable to be determined or the trial was in progress and a current toileting program or trial was currently being used to manage the resident's urinary continence. The CAA Summary triggered urinary incontinence as a potential problem area and was checked off to proceed with care planning.

9/1/16 - A care plan for the problem "resident is incontinent of bowel & bladder with potential for improved control or management" was developed. Care plan approaches included "assist with toileting needs" and "toilet resident as she request (sic) and as needed." The facility failed to develop an individualized toileting plan for R74 based on the 3 day voiding diary.

9/1/16 through 10/30/16 - The ADL Record, completed by CNAs, stated R74 was totally incontinent of bladder.

10/30/16 - R74 was discharged to the hospital and returned to the facility on 11/1/16.

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11/1/16 - The Clinical Admission (re-admission) Documentation report checked off that R74 had "no obvious problem" with urinary function. The document did not identify urinary incontinence.

11/2/16 through 11/30/16 - The ADL Record, completed by CNAs, stated R74 was totally incontinent of bladder.

11/3/16 3 PM through 11/6/16 - A re-admission Bowel and Bladder Evaluation was completed, including a 3 day voiding diary. The evaluation failed to identify the type of incontinence R74 had. Handwritten on the evaluation was "Toilet res (resident) as she request (sic)." There were no changes made to the incontinence care plan.

11/7/16 - A progress note stated, "Completion of 3 days post readmission Bladder and Bowel eval (evaluation) showed that resident is totally incontinent of Bladder...Current toileting plan is to 'toilet resident as she request (sic) and as needed.' Will continue current plan of care in place at this time."

11/21/16 through 11/24/16 - A quarterly Bowel and Bladder Evaluation was completed, including a 3 day voiding diary. The evaluation failed to identify the type of incontinence R74 had, to identify the type of toileting program in use and to be signed and dated by a nurse. Review of the 3 day voiding diary revealed that on eight (8) occasions, R74 was assisted to toilet with result (was continent). Again, there were no changes made to R74's incontinence care plan.

12/1/16 - R74 was discharged from the facility.

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The facility failed to accurately and completely assess R74's urinary continence status and failed to develop an individualized toileting plan in an attempt to restore continence to the extent possible.

2/14/17 approximately 4:45 PM - Findings were reviewed with E2 (DON) and E8 (Corporate Nurse Consultant). E2 and E8 confirmed the lack of a comprehensive assessment and lack of an individualized toileting plan for R74.

2. R85's clinical record revealed the following:

11/7/16 - R85 was readmitted to the facility with a diagnosis that included Clostridium Difficile Colitis.

11/7/16 at 8:41 PM - R85's clinical admission assessment stated that he had no urinary issues.

11/8/16 through 11/10/16 - Review of the 3-day voiding diary, documented on the Bowel and Bladder Evaluation, revealed that R85 was incontinent of urine on 11/8/16 (8 AM and 1 PM), 11/9/16 (7 AM) and 11/10/16 (7 AM, 8 AM and 12 PM).

11/8/16 through 11/25/16 - Review of R85's ADL Record revealed that out of 53 total shifts, he was continent of urine on 28 shifts, incontinent of urine on 24 shifts and one shift lacked documentation.

11/8/16 through 11/25/16 - Review of R85's clinical record revealed the absence of an urinary incontinence care plan.

11/14/16 - Review of the Bowel and Bladder

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Evaluation, which included the 11/7/16 - 11/10/16 voiding diary, stated that R85 was occasionally incontinent of urine. The Evaluation failed to identify the type of incontinence. The facility placed R85 on the following toileting schedule: toilet upon arising, before meals and bed.

11/14/16 - The 5-day MDS assessment stated that R85 was cognitively impaired, frequently incontinent of urine, required staff assistance of 1 person for toilet use and currently on a toileting program.

11/15/16 through 11/25/16 - R85's Flow Record stated to toilet upon arising, before meals and bed. In addition, each shift documented if the toileting program was effective or ineffective. Out of 31 total shifts reviewed, there were 24 shifts that stated the toileting program was ineffective and 7 shifts lacked documentation. The facility failed to respond to R85's "ineffective" toileting program (as per CNA monitoring).

11/25/16 - R85 was discharged to the hospital and readmitted to the facility on 11/29/16.

11/29/16 through 12/2/16 - A 3-day voiding diary, documented on the Bowel and Bladder Evaluation, revealed that R85 was incontinent of urine on 11/29/16 (6 PM and 9 PM) and on 11/30/16 (5 AM).

Undated - Review of the Bowel and Bladder Evaluation, which included the 11/7/16 - 11/10/16 voiding diary, stated that R85 was continent of urine despite documented evidence of R85's urinary incontinence in the 3-day voiding diary. The Evaluation stated that based on R85's bowel incontinence, the facility placed him on the

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following toileting schedule: toilet before meals and bed. The facility failed to identify and comprehensively assess R85's urinary incontinence.

11/29/16 through 12/2/16 - R85's ADL Record stated that he was continent of urine on 8 out of 8 shifts. R85's ADL Record contradicted his 3-day voiding diary that was completed at the same time from 11/29/16 through 12/2/16, which showed that he was incontinent of urine 3 times.

11/29/16 through 12/2/16 - R85's Flow Record stated that he was toileted before meals and bed. In addition, each shift documented if the toileting program was effective or ineffective. Out of 8 total shifts reviewed, there were 6 shifts that stated the toileting program was ineffective and 2 shifts lacked documentation. The facility failed to respond to R85's "ineffective" toileting program.

11/29/16 through 12/2/16 - Review of R85's clinical record revealed the absence of a urinary incontinence care plan.

12/2/16 - R85 was discharged to the hospital and readmitted to the facility on 12/8/16.

12/8/16 through 12/11/16 - A 3-day voiding diary, documented on the Bowel and Bladder Evaluation, revealed that R85 was incontinent of urine on 12/10/16 (12 PM) and 12/11/16 (9 AM and 1 PM).

12/8/16 through 12/23/16 - R85's ADL Record revealed that out of 44 total shifts reviewed, he was continent of urine on 38 shifts, incontinent of urine on 3 shifts and 3 shifts lacked documentation.

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12/8/16 through 12/23/16 - Review of R85's clinical record revealed the absence of a urinary incontinence care plan.

12/11/16 through 12/23/16 - R85's Flow Record stated that he was toileted before meals and bed. In addition, each shift documented if the toileting program was effective or ineffective. Out of 35 shifts reviewed, there were 31 shifts that stated the toileting program was ineffective and 4 shifts lacked documentation. The facility failed to respond to R85's "ineffective" toileting program.

12/14/16 - The Bowel and Bladder Evaluation, which included the 12/8/16 - 12/11/16 voiding diary, was reviewed. The Evaluation was incomplete as it failed to identify R85's type of urinary incontinence. The Evaluation stated that R85 was on scheduled voiding, his condition was declining and currently had C-Diff. The facility failed to comprehensively assess R85's urinary incontinence.

12/23/16 - R85 was discharged to the hospital and readmitted to the facility on 12/27/16.

12/27/16 at 10:22 PM - R85's clinical admission assessment stated that he had no urinary issues.

12/27/16 through 12/29/16 - A 3-day voiding diary revealed that R85 was incontinent of urine on 12/28/16 (5 AM) and 12/29/16 (5 AM).

12/27/16 through 12/31/16 - R85's Flow Record lacked evidence that R85 was on a toileting program.

12/27/16 through 1/16/17 - R85's ADL Record

Richard Powell NHA 3/14/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 23	F 315		4/19/17

stated that out of 59 shifts reviewed, he was incontinent of urine on 46 shifts and continent on 13 shifts.

12/27/16 through 1/16/17 - Review of R85's clinical record revealed the absence of a urinary incontinence care plan.

1/1/17 through 1/16/17 - R85's Flow Record stated that he was toileted before meals and bed. In addition, each shift documented if the toileting program was effective or ineffective. Out of 46 total shifts reviewed, there were 4 shifts that stated the toileting program was ineffective and 42 shifts had CNA initials documented. It was unclear how the facility individualized his toileting program when the facility failed to comprehensively assess his urinary incontinence. It was also unclear how the facility was monitoring R85's toileting program.

1/4/17 - R85's Bowel and Bladder Evaluation, including the 3-day voiding diary from 12/27/16 through 12/29/16, was reviewed. Despite documented evidence of urinary incontinence during the 3-day voiding diary, the facility's evaluation stated that R85 was continent of urine and incontinent of bowel. R85 was placed on the previous "ineffective" toileting program for bowel incontinence and his urinary incontinence was not addressed. It was unclear why it took the facility six (6) days to review and analyze the Bowel and Bladder evaluation.

1/16/17 - R85 was discharged to the hospital and readmitted to the facility on 1/26/17.

1/19/17 - The quarterly MDS assessment stated that R85 was always incontinent of urine and

Richard Powell NHA 3/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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required total assistance of 2 staff for toileting use. The facility failed to accurately reflect R85's urinary status on this assessment as he was frequently incontinent.

1/26/17 through 1/29/17 - A 3-day voiding diary, documented on the Bowel and Bladder Evaluation, revealed that R85 had urinary incontinence on 1/26/17 (3 PM and 7 PM), 1/27/17 (9 AM, 5 PM and 8 PM), 1/28/17 (3 AM and 5 AM) and 1/29/17 (9 AM).

1/26/17 through 1/31/17 - R85's ADL Record stated that out of 16 shifts reviewed, he was incontinent of urine on 10 shifts and continent on 6 shifts.

1/26/17 through 1/31/17 - Review of R85's Flow Record lacked evidence of a toileting program.

Undated - Review of the Bowel and Bladder Evaluation, which included the 3-day voiding diary from 1/26/17 through 1/29/17, revealed that it was not reviewed and analyzed. The evaluation stated that R85 was readmitted to the hospital.

1/26/17 through 2/8/17 - Review of R85's clinical record revealed the absence of a urinary incontinence care plan.

1/31/17 - R85 was discharged to the hospital and readmitted to the facility on 2/8/17.

2/16/17 at 11:52 AM - During an interview, findings were reviewed and confirmed with E2 (DON) and E6 (UM/RN). The facility failed to ensure that R85, a resident who was incontinent of bladder, received appropriate treatment and services to restore continence to the extent

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 315	Continued From page 25 possible by the: - failure to comprehensively assess R85's urinary incontinence after multiple readmissions on 11/7/16, 11/29/16, 12/2/16, 12/27/16 and 1/26/17; - failure to develop an individualized urinary incontinence care plan from 11/8/16 through 2/8/17; and - failure to address R85's "ineffective" toileting program; and - failure to accurately reflect R85's urinary status on the 1/19/17 quarterly MDS assessment.	F 315		4/19/17
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323	F323 A. 1. Once informed by the surveyor the sagging wire in room 110 was fixed and the uncovered long bolts in room 111 was covered. B. 1. All residents have the potential to be affected by this practice. 2. The ED, Director of Housekeeping and Maintenance Director will round every resident room to check for the loose wires and uncovered bolts. Repairs will be made accordingly. c. 1. The ED, Director of Housekeeping and Maintenance Director will initiate weekly room round and monitor for loose wires and uncovered bolts. Repairs will be made accordingly. D. 1. The ED/designee will audit 25% of resident's room weekly. 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved.	

Richard Powell NHA 3/14/17

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F 323	Continued From page 26 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to minimize accident hazards for 2 rooms (East 110 and 111) out of 30 rooms. Findings include: The following was observed on 2/13/17 from 2:00 PM to 2:45 PM during the Stage 2 environmental tour: East 110 - The wire protector behind the bed was sagging from the wall; East 111 - The toilet had long uncovered bolts. Findings were reviewed and confirmed with E10 (Director of Housekeeping) and E11 (Director of Maintenance) on 2/13/17 at approximately 2:45 PM. Findings were reviewed with E1 (NHA) and E2 (DON) on 2/16/17 at approximately 5:50 PM.	F 323		4/19/17
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		

Richard Parnell NHA 3/14/17

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F 329	Continued From page 27 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R25) out of 26 Stage 2 sampled residents the facility failed to ensure that the resident's drug regimen was free from unnecessary drugs. The facility failed to ensure that a weekly EKG was completed according to physician's orders for R25, who was receiving the antipsychotic medication Seroquel, in order to monitor for adverse consequences. Findings include: Review of R25's clinical record revealed the following: 5/26/16 - R25 was admitted to the facility with diagnoses that included advanced dementia with behavioral disturbance. 5/26/16 - A hospital Interagency Discharge Order sheet and the facility physician's admission order sheet revealed an order for R25 to have a weekly EKG to check QT interval as the resident was on Seroquel. Additionally, the hospital Interagency Orders stated to maintain the QT interval equal to or less than 510.	F 329	F329 A. R25's EKG was discontinued by the physician on 2/3/17, B. 1. All residents that have Radiology testing ordered have the potential to be affected by this practice 2. The DON/designee will do an all house audit on resident's medical record that have had Radiology testing in the past 30 days to monitor that the testing was completed. The physician and the POA will be notified accordingly. C. 1. The staff educator will educate license nurses on how to follow up on incomplete Radiology testing. 2. Weekly Radiology report within Matrix Care will be revised by the DON/designee for compliance. The report will be discussed in morning meeting and follow up will be conducted as needed, D. 1. The DON/designee will run a weekly report on all residents that have had radiology testing to monitor for testing. 2. Results of the audits will be reported in the monthly QA & A meeting until 100% compliant is achieved.	4/19/17

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F 329	Continued From page 28 5/27/16 - A cardiology report revealed an EKG was completed and the QT interval was 440. 6/3/16 - A cardiology report revealed an EKG was completed, but there was no documented QT reading. 6/10/16 - The clinical record lacked evidence that an EKG was completed. 6/17/16 - A cardiology report revealed an EKG was completed, but there was no documented QT reading. 6/24/16 through 1/27/17 - Review of the clinical record lacked evidence that any EKGs were obtained during this timeframe. Review of physician's orders revealed that a weekly EKG remained an active physician's order for R25. 6/24/16 through 1/27/17 - Review of the MARs revealed the weekly EKGs were not completed for seven (7) months. Nursing staff documented the following comments on the MARs: "Item unavailable," "No one came to do it," "Order faxed to mobilex," or "N/A." There was no evidence that there was any follow up by the facility regarding why the weekly EKGs were not completed. 2/3/17 - A physician's order was written to discontinue the weekly EKGs. 2/16/17 approximately 2 PM - During an interview, E2 (DON) stated she had been doing audits and noticed the weekly EKGs were not being completed as ordered. E2 stated she spoke with R25's physician, who then discontinued the order on 2/3/17.	F 329		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 29 2/16/17 approximately 3:10 PM - During an interview with E2 and E6 (Unit Manager) it was confirmed that there was no evidence of any follow up by the facility for seven (7) months as to why the weekly EKGs were not being completed. The facility failed to ensure that a weekly EKG was completed according to physician's orders for R25, who was receiving the antipsychotic medication Seroquel, in order to monitor for adverse consequences.	F 329		4/19/17
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (I) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of	F 412	F412. A. A dental appointment for R63 has been scheduled, B. 1. All residents have the potential to be affected by this practice. 2. The SSW/designee will audit all resident that had a dental CAA triggered in the past 90 days to monitor that dental appointments were made as indicated. Appointments will be made accordingly. C. 1. The SSW/designee will now discuss in morning meeting any resident that had a dental CAA triggered and will be tracked on the center's white board to track the date and time of the resident's dental appointment. D. 1. The SSW/designee will audit 100% of resident's that had a dental CAA triggered to monitor that dental appointments were made as indicated. 2. . Results of the audits will be reported in the monthly QA & A meeting until 100% compliance is achieved. ↓	

Richard Pond NHA 3/14/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 412	Continued From page 30	F 412		4/19/17

dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility failed to provide routine dental services to meet 1 (R63) out of 26 Stage 2 sampled resident's needs. Findings include:

R63 was admitted to the facility in June 2014.

According to the CAAs from the 6/2/16 annual MDS assessment, R63 had dental cavities and broken natural teeth.

A SS note, dated 6/3/16, stated that a voicemail message was left for [name of provider} Dental to place a dental consult for R63 regarding the annual exam. The note additionally stated that the Social Worker would follow up.

Record review lacked dental consultations and/or services.

During an interview with R63's POA on 2/9/17 at approximately 11 AM, he stated that he spoke with a SW about R63's dental follow-up (he did not state when) which has not been done.

E7 (SW) stated during an interview on 2/14/17 at approximately 1:45 PM, that she did not write the 6/3/16 note; a previous SW did. E7 stated that [Name of provider] Dental provides consults with a Dentist including initial assessments and surgery and hygienist cleanings are provided by [Name of second provider] Dental. E7 stated that the Dentist used does not write notes. E7 confirmed that she looked In R63's chart today

Richard Powell NHA
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F 412	Continued From page 31 and was unable to find any dental services, so she called [Name of provider] Dental and [Name of second provider] Dental to send copies of any services provided to R63. E7 stated that documentation by SS was in a different electronic system and was switched in August 2015 to the facilities current system and they can no longer access information from the previous system. About an hour later, E7 provided a copy of R63's name on a dental list for "cleaning/follow up", dated 12/15/14 and a copy of R63's facesheet information that was faxed to [Name of provider} Dental on 2/2/16 for an annual examination. R63 was observed during the survey with multiple missing teeth and some areas of teeth were dark. Findings were reviewed with E2 (DON) on 2/15/16 at approximately 12 PM and with E1 (NHA) and E2 on 2/16/17 at approximately 5:30 PM during the exit conference. The facility failed to provide routine dental services to provide for R63's needs.	F 412		4/19/17

Richard Powell NHA 3/14/17

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: February 16, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. **REVISED REPORT** An unannounced annual survey was conducted at this facility from February 8, 2017 through February 16, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records, other facility documentation and State Survey Agency records as indicated. The facility census the first day of the survey was 95. The Stage 2 survey sample size was 26.		4/19/17
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 16, 2017: F225, F241, F253, F278, F279, F309, F315, F323, F329, F412.		

Provider's Signature Richard Powell Title ED/NHA Date 4/7/17

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: February 16, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	16 Del. C., 1162 Nursing Staffing: (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios: RN/LPN — CNA* Day — 1 nurse per 15 res. — 1 alde per 8 res. Evening — 1:23 — 1:10 Night — 1:40 — 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. Three full Weeks of facility staffing, covering the period of 15 January 2017 through 4 February 2017 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Churchman Village (hereafter C.V.) staff, and signed by the Administrator. The **nine (9)** citations cited hereon result from that work. **The law was not met as evidenced by:** C.V. failed to meet the required 3.28 Daily Care Hours per Resident on the following **nine (9)** dates. The daily care hours attained by C.V. on the indicated date are parenthesed. 1. Sunday, 15 January, 2017, (3.23). 2. Sunday, 22 January, 2017, (3.23). 3. Sunday, 29 January, 2017, (3.26). 4. Friday, 3 February, 2017, (3.19). 5. Saturday, 4 February, 2017, (3.16)	Cross reference to the CMS 2567-Survey for the plan of ciorrection survey completed February 2/16/17 for F225, F241, F253, F278, F279, F309, F315, F323, F329, F412 1. The facility cannot retrospectively go back and add staffing for the 5 dates cited. 2. All resudents have the potential to be affected by this deficient practice. 3. (1) The scheduler/designee will run a PPD report daily to monitor that staffing is in compliance with Delaware Nursing Home Staffing Laws. Adjustments will be made accordingly. 4. (1) Now the scheduler/ designee will audit staffing daily for compliance with Delaware Nursing Home Staffing Laws. New Admissins, and staff lateness will be taken into consideration, (2) The results of the audits will be reported out to monthly QA&A until 100% compliance is achieved for 3 months.	4/19/17

Provider's Signature Richard Powell Title ED/NHA Date 4/7/17